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Board of Directors
Bay Bluffs Medical Care Facility

The healthcare industry continues in a period of rapid change, both in terms of capital requirements and changes in providing cost effective, high quality long-term care services. In an effort to best serve our clients, our knowledge of the healthcare industry is continually expanding to reflect this changing environment. We are hopeful the knowledge base we have obtained through serving Michigan and Ohio long term care facilities will assist in providing Bay Bluffs Medical Care Facility with both the vision and tools to be successful in this dynamic environment.

Through our recent audit, research, and participation in various healthcare provider associations, we are providing the following reports to assist you in deepening your knowledge base of items that may affect the Facility in the near future as well as potential areas for improvement in the Facility's operations:

I. Observations, Comments and Recommendations
II. Regulatory Heartbeat
    A. Reimbursement Update
    B. Office of Inspector General News
    C. Tax Developments
    D. HIPAA Update
    E. Other Healthcare News
III. Historical Financial Indicators

As required by auditing standards generally accepted in the United States of America, the independent auditor is required to make several communications to the "audit committee" or a governing body having oversight responsibility for the audit. The purpose of this report letter is to provide you with additional information regarding the scope and results of our audit and assist you with your oversight responsibilities of the financial reporting process for which management is responsible.

Thank you for the opportunity to be of service to the Facility. Should you wish to discuss any of the items included in this report, we would be happy to do so.

Sincerely,

PLANTE & MORAN, PLLC

J. Eric Conway

J. Eric Conway, FHFMA, CPA

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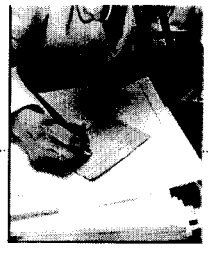
Observations, Comments, and Recommendations



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Board of Directors
Bay Bluffs Medical Care Facility

In planning and performing our audit of the financial statements of Bay Bluffs Medical Care Facility for the year ended December 31, 2004, we considered the Facility's internal control structure in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. The consideration we gave to the internal control structure was not sufficient for us to provide any form of assurance on it. We would like to thank Mike Greer and the rest of the accounting staff for their preparation and assistance during the audit. We are very pleased with the completeness and timeliness of the workpapers, which were prepared by the accounting staff. Their efforts have contributed greatly to the completion of the audit on schedule, and they should be congratulated for their efforts. In reviewing the Facility's processes and systems, we made a few observations we feel should be communicated to you. We have also summarized additional areas for Board consideration.

Our observations, comments, and recommendations are enclosed in the following exhibits:

Title	Exhibit
Defined Benefit Pension Plan	A
General Accounting Considerations	B
Electronic Health Records	C

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Exhibit A
Defined Benefit Pension Plan

Over the last few years, it has been noted that the Facility's defined benefit plan (Plan) is under-funded by over $1,000,000. The under funding measures the future liabilities using many assumptions provided by management to the Plan's actuary. Basically, it means that if everyone were eligible to start drawing from the Plan the Facility would be responsible to pay the under funded amount to cover the benefits. Because many of the Plan participants will not be eligible for some time, the Facility will likely have time to begin contributing to the Plan to eliminate the under funded amount before it is needed. The under funded status is a result of the ever-changing market conditions and changes in assumptions of the Plan.

We recommend the Facility begin to make the maximum contributions allowed until the plan is fully funded. Making the maximum contributions will allow the Facility to benefit from the increased costs in the cost report for the Medicaid rate calculation while Medicaid reimbursement is still based on costs.

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Exhibit B
General Accounting Considerations

During the course of our audit, we had the opportunity to observe the Facility's procedures for financial reporting. In that process, we identified various accounting issues that we wanted to bring to your attention. Although not significant in nature, we do recommend the Facility consider the comments below to strengthen various general accounting processes.

- During our audit we noted some checks listed as outstanding on the bank reconciliation for a long time were recognized as revenue in the current year. Although these checks were insignificant, we suggest recommend such checks be monitored and turned over to the State, as appropriate.

- In 2004, it was noted the Facility does not have a conflict of interest policy, with annual forms listing potential conflicts signed by each board member and senior management position. Complete documentation supporting management's actions with respect to transactions involving real or potential conflicts of interest, including the prudence of such transactions, is essential and should be readily available. Certainly, opinions of counsel provide both guidance and supporting documentation. However, counsel's opinion alone cannot prevent litigation and loss if management has acted improperly or imprudently. We recommend this policy be reviewed and conflict forms be signed by all Board Members on an annual basis.

- During the testing of cash disbursements, we noted an invoice was approved for payment and was charged to an unrelated expense account. We recommend writing the expense account number on the invoices and submitting both of these for approval to avoid misclassification in the future.

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Exhibit C
Electronic Health Records

Appropriate and concise documentation within medical records not only provides billers with the information necessary to code both effectively and efficiently, it also ensures public safety through reduction of medical errors, contributing to overall quality control and helps provide the Facility protection in liability issues.

The Institute of Medicine (IOM) has documented that more than 1 million serious medication errors occur annually in the United States. These errors result in preventable adverse drug events (ADEs), 20 percent of which are life-threatening. Additionally, the cost and inefficiency of the current system is well documented. Twenty-five cents out of every health care dollar is spent on unnecessary care or redundant tests. The current medical malpractice environment is also driving the healthcare industry. With the current appetite for litigation, it is more crucial than ever to begin to develop care protocols based on evidence that may be used widely as standards for care.

- We believe the ultimate management of health information will include the ability to aggregate and interpret large amounts of data through structured data elements that enable real time analysis across the care continuum through use of an electronic health record (EHR).

The Facility can derive the following benefits from an EHR system:

- Reduction of costs
- Ability to transfer, retrieve, and link information to different providers, regardless of location
- Capability to display data in different views over time
- Ability to abstract and report information over time
- Enhancement of compliance to regulatory and quality standards
- Capability to create a dynamic connection to practice and therapeutic guidelines with automatic warnings based on expected outcomes
- Ability to adequately prepare and retain the healthcare workforce
- Improved clinical documentation
- Reduction in medical errors
- More effective coding and reimbursement

Based upon the foreseeable focus on quality control, we recommend that the Facility consider the benefits of implementing an electronic health records system.

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Regulatory Heartbeat

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Plante & Moran Regulatory Heartbeat

Medicaid Updates

Michigan Medicaid Budget

The Medicaid budget for the fiscal year ending September 30, 2005 is not expected to provide for an inflation adjustment nor wage pass through funding. A new executive order is expected to increase the current reduction to variable costs, to cover the expected shortfall for fiscal 2005. Last year's budgetary reduction of 1.85 percent of the variable cost component is expected to continue. Early reports would indicate an additional 4.00 percent reduction calculated based on the facility's variable cost component plus the 1.85 percent reduction creating a total reduction of approximately 5.85 percent. There has been some mention of other cost containment measures which could further restrict the funding from Medicaid.

- The Medicaid Quality Assurance Supplementation (QAS) or similar program is currently being reviewed and the proposed changes to the current system are being evaluated but are not finalized. We hope to have the details of the new program in the near future. The intent of the program will be to provide some form of payment adjustment to cover the cost increases incurred since the base year used in the Medicaid rate setting.

Medicaid Provider Manual

Effective April 1, 2005, Bulletin MSA 05-14 was issued to provide a new Medicaid Nursing Facility Provider Manual Reimbursement Chapter and updated Coverages and Limitation Chapter. The policies under the Reimbursement Chapter are effective for cost report periods ending in calendar year 2005. The policies under the Coverages and Limitation Chapter were effective beginning January 1, 2004. These Chapters have been revised to incorporate and clarify existing policy and to set new policy. This bulletin replaces the current Long Term Care Manual Chapter VII and the current Nursing Facilities Chapter III.

Medicaid Leave Days

Effective January 1, 2001, Medicaid began reimbursing a nursing facility during a Medicaid resident's temporary absence from the facility for admission to the hospital for emergency medical treatment for up to 10 days. There must be a reasonable expectation by the attending physician that the resident will return from the hospital by the end of the tenth day, and there must be documentation of this in the medical record. The reimbursement rate for this service is approximately one-half the normal Medicaid rate per resident day.

Subsequent to September 30, 2004, Medicaid has changed the policy to eliminate payments for Medicaid Leave Days unless the facility maintains a minimum of 98 percent occupancy at the time of the request for Hospital Leave Days for a resident. The additional occupancy requirement is expected to make the billing and accounting for Hospital Leave Days more complicated. We recommend reviewing your current procedures to ensure proper documentation is maintained.

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Medicaid Updates (continued)

Cash Discounts for Early Payment

The State of Michigan Medicaid program can claim amounts due from a facility when the facility is charging a net amount to private pay residents that is less than the Medicaid rate (after the applicable cash discounts for early payment were applied). While this principle has been eliminated from many States for lack of a functional purpose, the requirement still exists in Michigan. It is uncertain whether Medicaid will continue to enforce their position; however it would be in the facility's best interest to avoid such a situation.

If your facility is following these basic guidelines when offering cash discounts, you should not have an issue with Medicaid attempting to pay less than the facility's calculated Medicaid rate. Those guidelines are as follows:

1) Be sure to set to private pay rates at least $5 to $10 above the projected Medicaid rates (in recent years, we would recommend an even higher markup because the Medicaid rates do not include an inflationary adjustment)

2) If you offer a cash discount for early payment, it must be reasonable in amount. For example, something similar to what your vendors might offer you for prompt payment (like a 2% discount if paid in ten days, or the full amount due in 30 days).

3) The amount of discount should reflect something similar to what might be saved by the facility when prompt payment is received (i.e. the cost of sending additional billings and the savings from bad debt write-offs).

Beginning in October 2005, the County Medical Care Facilities will likely be participating in the Quality Assurance Assessment Program (QAAP) or similar program which may require a bed tax to be paid in exchange for additional reimbursement paid separately from the Medicaid rate. The QAAP program may effectively reduce the portion of the Medicaid rate compared to the Private rate providing greater flexibility in setting private pay rates and allowing cash discounts.

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Medicare Updates

Medicare Rate Refinements

The Centers for Medicare and Medicaid Services (CMS) announced on July 29, 2004, the skilled nursing facility (SNF) Prospective Payment System (PPS) update includes a market basket update factor of 2.8 percent. The change in the PPS rates was effective October 1, 2004. There are other factors which will impact an individual facility's rates, including the wage index for the facility's geographic area.

We received good news in May 2005; an expansion of the number of RUG categories was announced in lieu of the removal of the "add-on" amounts currently included in the RUG rates, as previously threatened. The removal would have likely caused a negative impact of 10 to 15 percent in Medicare reimbursement for the average SNF provider. The combination of all factors mentioned above is expected to be revenue neutral.

Random and Focused Claims Review

We have recently been hearing reports of Medicare performing reviews of claims from the past few years. While PPS began in 1999, we had seen limited review activity in the first several years.

In May of 1999, HCFA published Program Memorandum A-99-20: Payment Safeguard Review of Skilled Nursing Facility Prospective Payment Bills. The memorandum directed that the methodology for review of skilled nursing facilities change from a review of services and expenses to a review of the beneficiary's clinical condition. The goal of the review is to identify inappropriate billing for SNF services and to ensure payment is not made for non-covered services.

Two types of reviews are to be conducted: random post-payment review and focused medical records review. Any SNF Prospective Payment System (PPS) claim submitted for payment is subject to random post-payment review. The information gained from the post-payment review will aid the intermediary in identifying criteria for focused medical records review. Additionally, other factors, such as unusual utilization of ancillary services or abnormal billing trends, will generate a focused medical records review.

Our experience with facilities that have undergone a focused medical records review has shown us a facility's best approach is being proactive, not reactive. The focused medical record reviews have led to some amount of lost reimbursement for each of the facilities due to lack of various types of documentation. The key to success is clearly some level of constructive self-evaluation to identify and correct problem areas before the facility is selected for review. The self-evaluation should include review of the clinical records as well as the billing records to ensure accuracy and consistency from the time the beneficiary arrives in the facility to the time the UB-92 (Uniform Billing form) leaves the facility.